

Autograph: Share 80 Plus Rx

› Preferred provider benefit plans insured by Humana Insurance Company



Texas

		Plan pays for services from NETWORK providers	Plan pays for services from NON-NETWORK providers
Deductible options¹ • per calendar year • copayments do not apply	• individual	\$3,500/\$5,000/\$6,000	\$7,000/\$10,000/\$12,000
	• family (two family members must each meet their individual deductible)	\$7,000/\$10,000/\$12,000	\$14,000/\$20,000/\$24,000
Deductible carryover	Covered expenses incurred in the last three months of the calendar year and applied to the deductible will be credited to the next calendar year deductible.		
Office visit copayment		\$35 primary care/\$50 specialist limited to 6 combined primary care and specialty care visits	Not applicable
Coinsurance out-of-pocket limit¹ • per calendar year • deductibles and copayments do not apply	• individual	\$2,000	\$8,000
	• family	\$4,000	\$16,000
Preventive care	• child immunizations (birth to age 6)	100%	100%
	• preventive office visits ^{2,3} • child immunizations (age 6 -18) ^{2,3} • Pap smear (birth to age 18) ^{2,3} • Pap smears (age 18 and older) • mammogram • prostate screening, colorectal detection screening	80%	60% after deductible
	• preventive lab and X-ray ^{2,3}	80% after deductible	60% after deductible
Physician services	• office visits (including allergy injections)	100% after office visit copayment up to 6 combined primary care and specialty care visits then 80% after deductible	60% after deductible
	• diagnostic lab and X-ray ⁴ • allergy testing	First \$200 per calendar year 100% then 80% after deductible	60% after deductible
	• allergy serum • inpatient and outpatient services • surgery ⁵	80% after deductible	60% after deductible
Facility services	• inpatient and outpatient services • outpatient surgery ³	80% after deductible	60% after deductible
	• emergency services (copayment waived if admitted)	80% after \$75 copayment per visit and deductible	80% after \$75 copayment per visit and deductible
Rx4 prescription drug⁶ • medical out-of-pocket maximum does not apply	• deductible per individual • benefit for each prescription or refill (up to 90-day supply; with applicable copay for each 30 day supply)	Separate \$1,000 deductible	
		Level 1	Level 2
		\$15*	\$35
		Level 3	Level 4
		\$55	25%
• copayment maximum (applies to Level 4 drugs only)		*Level 1 drugs subject to copay, no deductible \$2,500 per individual per calendar year	
• benefit per prescription or refill	100% after prescription copayment	70% after prescription copayment	
• mail order (up to 90-day supply)	100% after three times retail copay	70% after three times retail copay	
Other medical services • prior authorization required in order to be eligible for these benefits	• skilled nursing facility (up to 30 days per calendar year) • hospice ⁷ • home health care (up to 60 visits per calendar year) • durable medical equipment • pregnancy complications and sick baby services (no prior authorization required)	80% after deductible	60% after deductible
	• transplant services	80% after deductible when services are received from a Humana Transplant Network provider	60% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant
Lifetime maximum benefit		\$5,000,000 per covered person	
Mental health, chemical and alcohol dependency² • \$2,500 per calendar year • medical out-of-pocket maximum does not apply	• inpatient services • outpatient and office therapy sessions (outpatient services not to exceed \$500 of the total benefit)	75% after deductible	50% after deductible

continued ›

Texas Autograph: Share 80 Plus Rx

Optional benefits <ul style="list-style-type: none">• these are available to add for an additional cost• medical out-of-pocket maximum does not apply to drug coverage	<ul style="list-style-type: none">• prescription drug deductible• lifetime maximum• supplemental accident benefit (\$500 or \$1,000) (treatment must be provided within 90 days of the injury)	With this option \$500 deductible is required before Rx benefits are payable Increase to \$8,000,000 per covered person First \$500 per accident at 100%, then base plan benefits apply or First \$1,000 per accident at 100%, then base plan benefits apply
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To be covered, expenses must be medically necessary and specified as covered. Please see your policy for more information on medical necessity and other specific plan benefits.

1. When you obtain care from non-network providers:
 - 50 percent of your payment toward the deductible is credited to the deductible for network providers
 - 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for network providersOnce you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
2. Benefit payable after 90-day waiting period for preventive care and 30 day waiting period for mental health.
3. Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance
4. MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
5. Outpatient benefits payable after 90-day waiting period for nonemergency removal of tonsils and/or adenoids, and after 180-day waiting period for nonemergency surgical treatment for bunions, varicose veins, hemorrhoids or hernia (does not apply to strangulated or incarcerated hernia).
6. If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement. The covered person will also be responsible for 30% of the actual charge made by the dispensing pharmacy, after the applicable copayment.
7. Counseling for the hospice patient and immediate family is limited to 15 visits per family per lifetime. Medical Social Services limited to \$100 per family per lifetime.

Payments

Network providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to non-network providers are based on maximum allowable fees, as defined in your policy.

Non-network providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Network primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Medical limitations and exclusions

This is an outline of the limitations and exclusions for the HumanaOne individual health plan listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Your policy is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the policy.

Eligibility

The issue ages for HumanaOne individual health plans are two months to 64.5 years. The maximum age for a dependent child is 25 years.

Pre-existing conditions

A pre-existing condition is a sickness or injury which was diagnosed or treated, or which produced signs or symptoms that would cause an ordinarily prudent person to seek treatment, during the five-year period before the covered person's effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with us. We will waive the pre-existing conditions limitation for those conditions disclosed on the application provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Other expenses not covered

Unless stated otherwise no benefits are payable for expenses arising from:

1. Services not medically necessary or which are experimental, investigational or for research purposes.
2. Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
3. Services while confined in a hospital or other facility owned or operated by the United States government, provided by a person who ordinarily resides in the covered person's home or who is a family member, or that are performed in association with a service that is not covered under the policy.
4. Charges in excess of the maximum allowable fee or which exceed any policy benefit maximum.
5. Expenses incurred before the effective date or after the date coverage terminated.
6. Cosmetic procedures and any related complications except as stated in the policy.
7. Custodial or maintenance care.
8. Infertility services.
9. Pregnancy and well-baby expenses.
10. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
11. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids; dental exams.
12. Hearing exams (except for children from birth through 24 months of age), eye exams, routine physical examinations for occupation, employment, school travel, purchase of insurance or premarital tests.
13. Services received in an emergency room unless required because of emergency care.
14. Dental services (except for dental injury), appliances or supplies.
15. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
16. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
17. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.
18. Nicotine habit or addiction; educational or vocation therapy, services and schools; light treatment for Seasonal Affective Disorder (S.A.D.); alternative medicine; marital counseling; genetic testing, counseling or services; sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
19. Foot care services, except as stated in the policy.
20. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
21. Health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs; personal computers and related or similar equipment; communication devices other than due to surgical removal of the larynx or permanent lack of function of the larynx.
22. Hair prosthesis, hair transplants or implants and wigs.
23. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders, neuromuscular disorders, and any treatment for jaw, joint or head and neck.
24. Injury or sickness arising out of or in the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to a covered person qualifying as a sole proprietor, officer or partner under state law, and such benefits are not covered under any Worker's Compensation plan, provided the covered person is not covered under a Workers' Compensation plan.
25. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
26. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
27. Charges incurred for a hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.
28. Loss due to being intoxicated or under the influence of any narcotic unless administered on the advice of a health care practitioner.
29. Any drug, medicine or device which is not FDA approved.
30. Medications, drugs or hormones to stimulate growth.
31. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a noncovered injury or sickness.
32. Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-reviewed medical literature; experimental or investigational use drugs.
33. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
34. Drugs used in treatment of nail fungus.
35. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
36. Vitamins, dietary products and any other nonprescription supplements.
37. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions not a result of a mental disorder (other than for mental disorder with demonstrable organic disease).



Insured by Humana Insurance Company

Applications are subject to approval. Waiting periods, limitations and exclusions apply.

The HumanaOne brand of individual products are insured by subsidiaries of Humana, Inc.

This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.

Individual Dental Insurance

› Dental coverage (Traditional 100/50/50)

You can choose any dentist, but you can save up to 30 percent on out-of-pocket costs when you visit one of the more than 115,000 dentist locations in the PPO network. You can find a dentist by visiting Humana.com.

		Plan pays for services from NETWORK providers	Plan pays for services from NON-NETWORK providers
Preventive services	<ul style="list-style-type: none"> oral examinations routine cleanings x-rays sealants topical fluoride treatment 	100% no deductible	100% no deductible
Basic services	<ul style="list-style-type: none"> emergency care for pain relief thumb sucking and harmful habit appliances space maintainers amalgam, composite fillings (front/anterior teeth only) oral surgery routine extractions non-cast stainless steel crowns partial or complete denture repairs/adjustments 	50% after deductible	50% after deductible
<ul style="list-style-type: none"> six month waiting period applies 			
Major services	<ul style="list-style-type: none"> endodontics (root canals) periodontics crowns inlays and onlays partial or complete dentures denture relines/rebases removable or fixed bridgework 	50% after deductible	50% after deductible
<ul style="list-style-type: none"> twelve month waiting period applies 			
Teeth whitening	<ul style="list-style-type: none"> \$200 lifetime maximum 	50% after deductible	50% after deductible
<ul style="list-style-type: none"> six month waiting period applies 			
Orthodontia	<ul style="list-style-type: none"> Members can receive up to 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount. 		
Annual deductible		\$50 individual / \$150 family	
Annual maximum		\$1,000	

This is not a complete disclosure of plan qualifications and limitations. Please review the specific Dental Limitations & Exclusions before applying for coverage. Your billing and effective date for this plan will be the same as your medical plan and your dental premium will be collected along with your medical premium.

HumanaOne Dental and Life

Individual Dental Insurance

› Dental C550 DHMO plan

With the C550 DHMO plan, you choose a participating primary care dentist. There are no yearly maximums, no deductibles to meet and no waiting periods. Copayments for listed procedures are applicable only at a participating primary care dentist.

Member costs listed here are for services provided by your chosen participating primary care dentist only. Your primary care dentist may decide that you need to see a contracted specialty dentist. No referral is necessary to see a participating specialty dentist.

Specialty services: Should you need specialty care, (i.e., endodontist, oral surgeon, periodontist, pediatric dentist), you may be referred by your participating general dentist, or you may choose any participating specialty dentist. For this plan and benefits for procedures not listed on the schedule, members will receive a 25 percent discount by visiting a participating specialty dentist.

Summary of services

Appointments member pays

D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	\$ 30.00
D9430	Office visit (normal hours)	\$ 10.00
D9440	Office visit (after regularly scheduled hours)	\$ 35.00
D9999	Emergency visit during regularly scheduled hours, by report	20.00
D9999	Broken appointments (without 24 hr notice, per 15 min) Maximum \$40 per broken appointment. No charge will be made due to emergencies.	\$ 10.00

Diagnostic member pays

D0120	Periodic oral examination	no charge
D0140	Limited/comprehensive/detailed and extensive oral eval	no charge
D0150	Limited/comprehensive/detailed and extensive oral eval	no charge
D0160	Limited/comprehensive/detailed and extensive oral eval	no charge
D0180	Comprehensive periodontal evaluation.	\$ 25.00
D0210	X-ray intraoral—complete series including bitewings	no charge
D0220	X-ray intraoral—periapical, first film	no charge
D0230	X-ray intraoral—periapical, each additional film	no charge
D0270	X-ray bitewing—single film	no charge
D0272	X-ray bitewings—two films	no charge
D0274	Bitewings—four films	no charge
D0330	Panoramic film	no charge
D0460	Pulp vitality tests	no charge
D0470	Diagnostic casts	no charge

Preventive member pays

D1110	Prophylaxis—adult, routine (once every 6 months)	no charge
D1120	Prophylaxis—child, routine (once every 6 months)	no charge
D1110	Prophylaxis—adult/child, (additional)	\$ 35.00
D1120	Prophylaxis—adult/child, (additional)	\$ 35.00
D1201	Topical application of fluoride (including prophylaxis)—child (up to 16 years of age)	no charge
D1203	Topical application of fluoride (not including prophylaxis)—child (up to 16 years of age)	no charge
D1330	Oral hygiene instruction	no charge
D1351	Sealant-per tooth	\$ 20.00
D1510	Space maintainer—fixed, unilateral	\$65.00+lab
D1515	Space maintainer—fixed, bilateral	\$65.00+lab
D1520	Space maintainer—removable, unilateral	\$105.00+lab
D1525	Space maintainer—removable, bilateral	\$105.00+lab
D1550	Recementation of space maintainer	\$ 20.00

Restorative member pays

D2140	Amalgam—one surface, primary or permanent	\$ 30.00
D2150	Amalgam—two surfaces, primary or permanent	\$ 35.00
D2160	Amalgam—three surfaces, primary or permanent	\$ 40.00
D2161	Amalgam—four or more surfaces, primary or permanent.	\$ 50.00
D2940	Sedative filling	\$ 30.00
D2999	Sedative base (under fillings), by report	no charge

Resin restorative member pays

D2330	Resin based composite—one surface, anterior	\$ 50.00
D2331	Resin based composite—two surfaces, anterior	\$ 55.00
D2332	Resin based composite—three surfaces, anterior	\$ 65.00
D2391	Resin based composite—one surface, posterior	\$ 90.00
D2392	Resin based composite—two surfaces, posterior	\$110.00
D2393	Resin based composite—three surfaces, posterior	\$130.00
D2394	Resin based composite—four or more surfaces, posterior	\$150.00
D2510	Inlay—metallic, one surface	\$155.00
D2520	Inlay—metallic, two surfaces	\$165.00
D2530	Inlay—metallic, three or more surfaces	\$190.00

Crown and bridge member pays

D2740	Crown—porcelain/ceramic substrate	\$370.00+lab
D2750*	Crown—porcelain fused to high noble metal	\$370.00
D2751	Crown—porcelain fused to predominantly base metal	\$370.00
D2752*	Crown—porcelain fused to noble metal	\$370.00
D2790*	Crown—full cast high noble metal	\$370.00
D2791	Crown—full cast predominantly base metal	\$370.00
D2792*	Crown—full cast noble metal	\$370.00
D2910	Recement inlay	\$ 30.00
D2920	Recement crown	\$ 30.00
D2930	Prefabricated stainless steel crown—primary tooth	\$120.00
D2950	Core buildup, including any pins	\$ 60.00
D2951	Pin retention—per tooth, in addition to restoration	\$ 30.00
D2952	Cast post and core in addition to crown	\$120.00+lab
D2953	Each additional cast post—same tooth	\$120.00+lab
D2954	Prefabricated post and core in addition to crown	\$120.00
D2962	Labial veneer (porcelain laminate)—laboratory	\$370.00+lab

Endodontics member pays

D3220	Therapeutic pulpotomy	\$ 50.00
D3221	Pulpal debridement, primary and permanent teeth	\$130.00
D3310	Root canal therapy—anterior (excluding final restoration)	\$250.00
D3320	Root canal therapy—bicuspid (excluding final restoration)	\$350.00
D3330	Root canal therapy—molar (excluding final restoration)	\$450.00
D3410	Apicoectomy/periradicular surgery—anterior	\$200.00

Periodontics (gum treatment) member pays

D4210	Gingivectomy/gingivoplasty per quadrant	\$200.00
D4211	Gingivectomy/gingivoplasty per tooth	\$ 55.00
D4341	Periodontal scaling and root planing, per quadrant	\$ 65.00
D4342	Periodontal scaling and root planing 1 to 3 teeth per quadrant	\$ 65.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$ 60.00
D4381	Localized delivery of chemotherapeutic agents (per tooth)	\$ 60.00
D4910	Periodontal maintenance	\$ 65.00

HumanaOne Dental and Life

Prosthodontics		member pays
D5110	Complete denture—maxillary	\$375.00+lab
D5120	Complete denture—mandibular	\$375.00+lab
D5130	Immediate denture—maxillary	\$375.00+lab
D5140	Immediate denture—mandibular	\$375.00+lab
D5211 [^]	Maxillary partial denture—resin base	\$375.00+lab
D5212 [^]	Mandibular partial denture—resin base	\$375.00+lab
D5213 [^]	Maxillary partial denture—cast metal framework, resin denture bases	\$375.00+lab
D5214 [^]	Mandibular partial denture—cast metal framework, resin denture bases	\$375.00+lab
D5410	Adjust complete denture—maxillary	\$ 30.00
D5411	Adjust complete denture—mandibular	\$ 30.00
D5421	Adjust partial denture—maxillary	\$ 30.00
D5422	Adjust partial denture—mandibular	\$ 30.00

Repairs to prosthetics		member pays
D5510	Repair broken complete denture base	\$30.00+lab
D5520	Replace missing or broken teeth—complete denture (each tooth)	\$30.00+lab
D5610	Repair resin denture base	\$30.00+lab
D5630	Repair or replace broken clasp	\$30.00+lab
D5640	Replace broken teeth—per tooth	\$30.00+lab
D5650	Add tooth to existing partial denture	\$45.00+lab
D5730	Reline complete maxillary denture (chairside)	\$ 65.00
D5731	Reline complete mandibular denture (chairside)	\$ 65.00
D5740	Reline maxillary partial denture (chairside)	\$ 65.00
D5741	Reline mandibular partial denture (chairside)	\$ 65.00
D5750	Reline complete maxillary denture (laboratory)	\$50.00+lab
D5751	Reline complete mandibular denture (laboratory)	\$50.00+lab
D5760	Reline maxillary partial denture (laboratory)	\$50.00+lab
D5761	Reline mandibular partial denture (laboratory)	\$50.00+lab
D5850	Tissue conditioning—maxillary	\$ 45.00
D5851	Tissue conditioning—mandibular	\$ 45.00

Prosthodontics (fixed)		member pays
D6210*	Pontic—cast high noble metal	\$370.00
D6211	Pontic—cast predominantly base metal	\$370.00
D6212*	Pontic—cast noble metal	\$370.00
D6240*	Pontic—porcelain fused to high noble metal	\$370.00
D6241	Pontic—porcelain fused to predominantly base metal	\$370.00
D6242*	Pontic—porcelain fused to noble metal	\$370.00
D6750*	Crown—porcelain fused to high noble metal	\$370.00
D6751	Crown—porcelain fused to predominantly base metal	\$370.00
D6752*	Crown—porcelain fused to noble metal	\$370.00
D6790*	Crown—full cast high noble metal	\$370.00
D6791	Crown—full cast predominantly base metal	\$370.00
D6792*	Crown—full cast noble metal	\$370.00
D6930	Recent fixed partial denture (per unit)	\$ 25.00

Extractions/oral and maxillofacial surgery		member pays
D7111	Coronal remnants, deciduous tooth	\$ 35.00
D7140	Extraction, erupted tooth or exposed tooth	\$ 35.00
D7210	Surgical removal of erupted tooth	\$ 55.00
D7220	Removal of impacted tooth—soft tissue	\$100.00
D7230	Removal of impacted tooth—partially bony	\$125.00
D7240	Removal of impacted tooth—completely bony	\$150.00
D7250	Surgical removal of residual tooth roots	\$ 65.00
D7310	Alveoloplasty in conjunction with extractions—per quadrant	\$ 65.00
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	\$100.00
D7510	Incision and drainage of abscess—intraoral	\$ 40.00

Adjunctive general services		member pays
D9215	Local anesthesia	no charge
D9230	Analgesia (nitrous oxide, per 15 minutes)	\$ 30.00
D9450	Case presentation, detailed and extensive treatment planning	no charge
D9951	Occlusal adjustment—limited	\$ 40.00
D9952	Occlusal adjustment—complete	\$225.00

* The above copayments do not include the additional cost of precious (high noble) and semi-precious (noble) metal. The additional cost of precious metal shall not exceed \$125 per unit and \$75 per unit for semi-precious metal.

Note:

- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
- Unlisted procedures are at the dentists usual fee less 25%.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional \$50 per unit.
- Your billing and effective date for the DHMO plan will be determined once your medical plan is issued. The effective date can be between 15 and 45 days after the medical plan is issued.
- The initial payment will be taken at the time the dental policy is issued; subsequent payments will be billed on the 15th of each month. All billing and payments will be separate from your medical plan and will occur through CompBenefits, a Humana company.

Individual Term Life Insurance

With HumanaOne term life, you can buy a higher amount of insurance protection at a lower cost. You own the policy and maintain control, providing more flexibility for your family.

Coverage amounts	• Amounts start at \$25,000 and can go up to a maximum of \$150,000
Term levels	• Ages 18-65 for a 10-year level premium term • Ages 18-60 for a 15-year level premium term • Ages 18-55 for a 20-year level premium term
Rate guarantee	• Rates are guaranteed for the full term of the policy
Renewals	• HumanaOne Term Life Insurance is guaranteed renewable to age 95. Premiums after the initial level premium period will increase annually, but are also guaranteed.

Individual Dental Limitations and Exclusions

› Dental coverage (Traditional 100/50/50)

This is an outline of the limitations and exclusions for the HumanaOne Individual Dental Plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

Unless stated otherwise, no benefits are payable for expenses arising from:

1. The course of any occupation or employment for compensation, profit or gain, for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or where such coverage was available, regardless of whether the coverage was actually applied for.
2. Services and supplies for which no charge is made, or for which the covered person would not be required to pay in the absence of insurance.
3. Services furnished by or payable under any plan or law through any Government or any political subdivision.
4. Services furnished by any hospital or institution owned or operated by the United States Government, unless legally required to pay.
5. War or any act of war, whether declared or not; or any act of international armed conflict or any conflict involving armed forces of any international authority.
6. Completion of forms or failure to keep an appointment with a dentist.
7. Cosmetic dentistry, except as stated in the policy.
8. Any service related to altering vertical dimension; restoration or maintenance of occlusion; splinting teeth; replacing tooth structures lost as a result of abrasion, attrition or erosion; or bite registration or bite analysis.
9. Bone grafts, regeneration, augmentation or preservative procedures in edentulous sites.
10. Implants, including any crowns or prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with it; or other customized attachments.
11. Infection control.
12. Fees for treatment by other than a dentist, except as stated in the policy.
13. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthesiologist.
14. Prescription drugs or pre-medications, whether dispensed or prescribed.
15. Any service not listed as a covered expense.
16. Any service not considered a dental necessity, does not offer a favorable prognosis, does not have uniform professional endorsement, or is experimental or investigational in nature.
17. Expenses incurred prior to the effective date or after the date coverage is terminated, except for any extension of benefits.
18. Services provided by a person who ordinarily resides in the covered person's home or who is a family member.
19. Charges in excess of the reimbursement limit for the service or supply.
20. Treatment as a result of an intentionally self-inflicted injury or bodily illness, while sane or insane.
21. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with impression or placement of a restoration, charged as a separate service.
22. Repair and replacement of orthodontic appliances.

› Dental C550 DHMO plan

This is an outline of the limitations and exclusions for the HumanaOne Individual Dental Plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

1. No service of any dentist other than a participating general dentist or participating specialist will be covered by company, except out-of-area emergency care as provided in Section VII, Paragraph C of the Certificate.
2. Whenever any contributions or copayments are delinquent. Member will not be entitled to receive benefits, transfer dental facilities, or enjoy any of the other privileges of a member in good standing.
3. Company does not provide coverage for the following services:
 - a. Cost of hospitalization and pharmaceuticals, drugs or medications.
 - b. Services which in the opinion of the participating general dentist or participating specialist are not necessary treatment to establish and/or maintain the member's oral health.
 - c. Any service that is not consistent with the normal and/or usual services provided by the participating general dentist or participating specialist or which in the opinion of the participating general dentist or participating specialist would endanger the health of the member.
 - d. Any service or procedure which the participating general dentist or participating specialist is unable to perform because of the general health or physical limitation of the member.
 - e. Any dental treatment started prior to the member's effective date for eligibility of benefits.
 - f. Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.
 - g. Treatment for cysts, neoplasms, and malignancies.
 - h. General anesthesia.



Insured by Humana Insurance Company, or HumanaDental Insurance Company. Insured or administered by DentiCare, Inc. (d/b/a CompBenefits)
Applications are subject to approval. Waiting periods, limitations and exclusions apply.
The HumanaOne brand of individual products are insured by subsidiaries of Humana, Inc.

This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.